WISCONSIN MEDICAID
PRIOR AUTHORIZATION / HEALTH AND BEHAVIOR INTERVENTION ATTACHMENT (PA/HBA) COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form and is formatted exactly like this form. If necessary, attach additional pages if more space is needed. Providers should refer to their service-specific handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid medical consultants to make a reasonable judgment about the case.

Attach the completed Prior Authorization/Health and Behavior Intervention Attachment (PA/HBA) to the Prior Authorization Request Form (PA/RF), HCF 11018, and physician prescription and send it to Wisconsin Medicaid. Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616 or by mail to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

INSTRUCTIONS

The information contained in the PA/HBA is used to make a decision about the amount and type of intervention that is approved for Wisconsin Medicaid reimbursement. Thoroughly complete each section and include any material that would be helpful to support the medical necessity of the services being requested. When noted in these instructions, material from personal records may be substituted for the information requested on the form. When substituting material from personal records, indicate the purpose of the materials.

Prior authorization for health and behavior interventions is not granted when another provider already has an approved PA for health and behavior intervention services for the same recipient. In these cases, Wisconsin Medicaid recommends that the recipient request that the other provider notify Wisconsin Medicaid that they have discontinued treatment with this recipient. The recipient may also submit a signed statement of his or her desire to change providers and include the date of the change. The new provider's PA may not overlap with the previous provider's PA.

SECTION I — RECIPIENT INFORMATION

Element 1 — Name — Recipient
Enter the recipient's last name, followed by his or her first name and middle initial. Use the Medicaid Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — Date of Birth — Recipient
Enter the date of birth of the recipient (MM/DD/YY).

Element 3 — Recipient's Medicaid Identification Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

SECTION II — PROVIDER INFORMATION

Element 4 — Name — Performing Provider
Enter the name of the therapist who will be providing the treatment.

Element 5 — Performing Provider's Medicaid Provider Number
Enter the eight-digit Medicaid provider number of the performing provider.

Element 6 — Telephone Number — Performing Provider
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

Element 7 — Credentials — Performing Provider
Enter the credentials of the therapist who will be providing treatment. The discipline should correspond with the name listed in Element 4.

SECTION III — CLINICAL INFORMATION

Element 8 — Physical Health Diagnosis Related to the Need for Health and Behavior Interventions
Enter the physical health diagnosis related to the need for health and behavior intervention services. Indicate the date the diagnosis was given and by whom.

Element 9 — Biopsychosocial Factors Related to the Recipient's Physical Health Status
Enter a summary of the biopsychosocial factors resulting from the recipient's physical health diagnosis as discovered in the health and behavior assessment. Indicate the date of the health and behavior assessment.

Element 10 — Treatment Modalities
Indicate the treatment modalities being implemented.

Element 11 — Treatment Schedule
Enter the anticipated length of sessions, frequency of sessions, and duration of services requested on this PA. If requesting sessions more frequently than once per week, indicate why they are needed. If a series of treatments is anticipated (e.g., frequent sessions for a few weeks, with treatment tapering off thereafter), indicate the total number of hours of treatment requested, the time period over which the treatment is requested, and the expected pattern of treatment. This quantity should match the quantity(ies) in Element 20 of the PA/RF. (Services at intensities lower than the average of one hour weekly may be approved for a duration of up to six months.)

Element 12 — Recipient's Measurable Goals of Treatment Modalities
Indicate the recipient's measurable goals of each treatment modality being requested.

Element 13 — Anticipated Duration of Treatment
Indicate the anticipated duration of treatment to address the issues related to the identified physical health diagnosis listed in Element 8.

Element 14 — Signature — Performing Provider

Element 15 — Date Signed

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